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Marianne O'Hare: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the healthcare of the future.

This week, Mark and Margaret speak with Leah Binder CEO of The Leapfrog Group dedicated to improving patient safety in America's hospitals. They just released the latest report on the number of preventable deaths in American hospitals a 161,000 last year alone, which is actually an improvement from the quarter million just a few years ago to talk about the hospital safety grade scorecard, and look at what leads to hospitals having for scores and outcomes.

Lori Robertson also checks in, Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the faith from the facts.

We end with a Bright Idea that's improving health and well-being in everyday lives. If you have comments, e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, iTunes, or wherever you listen to podcasts. You can hear us by asking Alexa to play the program Conversations on Health Care.

Now, stay tuned for our interview with Leah Binder of The Leapfrog Group on Conversations on Health Care.

Mark Masselli: We're speaking today with Leah Binder, President and CEO of Leapfrog Group, an independent nonprofit organization dedicated to improving safety and quality in American hospital care. Ms. Binder also launched the Hospital Safety Grade which just released its latest report on hospital safety across the country including the number of patient deaths due to medical errors. She has repeatedly been named to modern healthcare's hundred most influential people in healthcare. She earned her bachelor's degree from Brandeis University and two master's degrees from the University of Pennsylvania in communication and government. Leah, welcome back to Conversations on Healthcare.

Leah Binder: Well, thank you for having me. It's great to be here.

Mark Masselli: Yeah. It's four years now since we talked with you. We discussed the prevalence of deaths in American hospitals due to preventable causes, and it's really a staggering amount, quarter of a million deaths per year. Leapfrog has joined forces again with Johns Hopkins Institute for patient safety. You've

just released some new numbers and certainly, there's been an improvement, estimated 160,000 deaths. I'm wondering if you could share with our listeners the most revealing data from your report and why this problem still persists.

Leah Binder: Right. There's good news and there's bad news. The good news is that we have fewer avoidable deaths in hospitals. We have 161,000 attributed to measures in our Hospital Safety Grade. It's not actually all errors and accidents that can happen in hospitals, but it's the ones we can measure. It's fewer than when we measured it three years ago. I mean that's specifically 45,000 people who are alive today who might've died last year from something that was avoidable, so that's good news. Great news actually is that for many years, so many people have been really trying hard to improve the problem of patient safety but we never ever see our results, so seeing this is positive and powerful. But of course the bad news is 160,000 people, I mean that is a big number, that is 500 people a day. That's a really terrible problem, and it's completely solvable. These are just accidents and errors. These are not things that cost a lot of money to solve either. I mean, a hospital just need to follow rules. Everybody works there has to wash their hands. Everybody has to be vigilant and careful about the patient 24/7. It's not easy to do that, but it is not expensive and it's not impossible.

Margaret Flinter: Well Leah, as you say, 160,000 deaths is far too many. We know that the known causes, the surgical errors, the medical mistakes, medication errors, but your research reveals that a poor or a failing hospital score is a pretty good indicator that a patient is more likely to experience a medical error or a deadly mishap. So talk with us about how these hospitals scores are compiled, and really how do they act as a important guidepost for consumers seeking the best possible outcomes in their care. And also, are they a truly highly motivating factor in getting organizations and their staffs to change their behavior?

Leah Binder: Yes, they are motivational. We have seen some incredible efforts by hospitals to get that A, and so I want to give credit to the hospital community where that is happening. We are seeing enormous will and leadership brought to the table to really improve performance of hospitals and get that A. We know for all having been kids, most of us have had had get a letter grade.

Margaret Flinter: Yeah.

Leah Binder: You know how motivational it can be when you get that A B C D or F, and it really is motivational. We have 28 different

measures of safety. We're looking at errors and infection rates, never events rates, so things like leaving a sponge and after surgery unfortunately some of those terrible things do happen and we know when they happen. We also look at how they prevent those events. Do they have in place the right systems that are known to keep patients safe? For example, do they use an electronic system for prescribing drugs? That is the most common error made in hospitals is problems with medications. Imagine how easy it is to give someone a much higher dose than they should get. Electronic prescribing systems can prevent 40% or more of those from happening, so we're looking at those things.

When we asked John Hopkins to look at, well what's the death rate and what's the problem in A versus B versus C versus D and F hospitals? We want to know, are we actually showing that there is a difference? Because if there's no difference, we don't have the right method. The method we use from three years ago showed that there was major difference in the death rate between the different letter grades, and this year the difference is even more compelling than we found originally. Your chances of unavoidable death, getting killed in a D and F hospital is 92% greater than if you go to an A hospital, so almost twice as likely to die of an error or an infection. Actually you're 88% more likely to die in a C hospital than in A hospital. Even the C hospitals show significantly poor performance than in A hospital, and B hospitals also were more likely to die, not as bad. The letter grade is relevant and everybody should really pay attention to it and also pay attention to it every six months because hospitals change. I'm amazed and impressed by how much effort hospitals put into getting that A, and they show results.

Mark Masselli: Leah, I am still trying to get my head around the 500 per day. That's a staggering amount. You have lots of people who weren't dead but were obviously caused enormous harm. Talk about the broader problem of patient harm and why that's so hard to track.

Leah Binder: Well, the problem with patient safety as it tends to be invisible. Typically we -- the way that we understand what's actually happening in healthcare and measure the quality is by billing data, which isn't exactly perfect. Billing data is meant to get hospitals paid, not to figure out how high quality service they're delivering. So a patient's safety is particularly difficult to track through billing data because typically hospital does not send a bill saying, oops the reason that's so high as, we made a big mistake. It's not going to say, oh, there was a

surgical site infection, that's why the patient was there for a month in the hospital or something. It's very hard to find a lot of these problems and errors. The reason we have better data now is because there've been many efforts to be better about it. There is now data coming out of CMS, which is the agency that runs medicare that requires hospitals to report their rates of different kinds of errors and infections, and that's where we get data. We also have to ask hospitals cause there's lots of things we don't know, they know. Leapfrog actually asks them to give us some data as well to help us to better understand infection rates and things like that. Hospitals giving us that data on their own is really what is ultimately going to tell us where the safety problems are.

Margaret Flinter: Well Leah, I think it's really important to note these aren't, arbitrary criteria. I think you've made that point really clearly and I think people can therefore take some real confidence in it. I have a bit of a two part question: one, you mentioned a couple of the measures and I wonder if you might just mention a couple of more, you talked about electronic prescribing, just to give our listeners or a more robust understanding. I have a part two to that, in the primary care domain, we are always factoring in the impact of the social determinants of health of poverty and literacy levels, education levels. Is there any factoring in of the social determinants when you are looking at this issue of preventable deaths in the hospital setting?

Leah Binder: Socioeconomic factors have a major impact on health systems and their ability to deliver top quality care. People's lives can be more complicated depending on where they live and depending on their poverty. There's clearly a need to recognize the differences in socioeconomic factors that can affect the performance of a health system. However, that should not change how we calculate performance. If a hospital is serving, we call it a safety net hospital, a community that is, let's say largely on Medicaid. If that hospital has a high death rate, we should still say you have a high death rate. We should also recognize and say, there are factors that contribute to that. There's ways that we can talk about the factors without having to say, we're going to report you as a lower death rate because your population is in poverty. That is not okay. We have to be very, very careful I think as we look at quality measurement nationally that we don't erase people's lives and say, well, we expect that because they're poor. We are looking only in our grades A, B, C, D and F only at errors and accidents, infections and injuries. We're only looking at those factors and most of those are not affected by demographic factors per se, one of the measures we look at is objects left in after surgery,

so sponges left in accidentally. It doesn't matter if the patient is rich or poor, a sponge should never be left in ever. We're looking at things that hospitals can control, they can make sure that they order medications correctly and make sure they get it to the right patient at the right time. Those are factors that we look at. We also look at what happens at the bedside, if they have the right systems in place for making sure that the right med gets to the right patient, which is also a problem. We look at coverage in the ICU making sure that there's a certified intensivist physician that can save lives by enormous factors. Those kinds of things aren't affected by the hospitals putting a high priority on safety.

Mark Masselli: We're speaking today with Leah Binder, President and CEO of Leapfrog Group, an independent nonprofit organization dedicated to improving safety and quality in American hospital care. Ms. Binder launched the Hospital Safety Grade, which just released its latest report on how hospitals scored across the country. You know, Leah, I was looking at the report and I'm going to move out of Connecticut. We're ranked 40th and I might well move to Washington State, which came out on top. Tell us how the state rankings are compiled, and are there other factors that go into that?

Leah Binder: Well, we do state rankings based on the percentage of hospitals in a state that earned an A from us. I would say Connecticut has been a concern. They have not been ranked high ever on our list of states, and they should be that is a state with some very significant hospitals. They are often pioneers and innovators. I'm very happy that you have great innovations, but when I walk in your hospital or my loved one does, don't give me an infection, thanks. New York, I'm just frustrated with New York because that's a state and the city, particularly New York City, where so much of the next generation of healthcare providers are being trained and yet their performance on safety is terrible. Whereas New Jersey, that's one of the top states in the country, they've consistently had very high percentage of As, and I think they're number six as a state. Maine has been in the top five really since we started grading hospitals. So there's real variation in states and a lot of it has to do with hospital associations. I've seen some great leadership from hospital associations in different states that are really put an emphasis on safety and really brought together leaders from different hospitals, including CEOs to try to share best practices and share some of their data with each others. So I think there's certainly very positive and promising results in states where they do have strong leadership from the hospitals.

Margaret Flinter: Well Leah, I wonder if I could get you to comment on another area that is of real concern to us, and that's what we're seeing with maternal death rates. Our maternal death rate is higher than the other industrialized countries. But also I know that the Leapfrog Group has been engaged for a number of years in a particular campaign to influence hospitals and expectant mothers and clinicians to reduce the number of planned early C-Sections. Could you talk about the larger issue of what Leapfrog is looking at or thinking about relative to maternal death, and also the impact of your specific campaign and how that perhaps has influenced outcomes?

Leah Binder: The Joint Commission, which is the accrediting organization that accredits the majority of hospitals in the country, I think they are about to finalize a measure that hospitals will be expected to adhere to on procedures they need to take to prevent maternal mortality. So I'm certain that the Joint Commission will not make that public by hospital, but Leapfrog can. We ask hospitals to voluntarily give us information we can't get and that will certainly be something we will look at to ask hospitals to give us what they gave to Joint Commission on whether they're complying with that because we agree it's disgraceful actually that our country has the highest rate of maternal death. There's just no excuse for that. This must stop, and I know we can stop this because we have done a great job in stopping another problem which you alluded to earlier, which is early elective deliveries. These are deliveries that are scheduled without a medical reason prior to 39 weeks. So prior to when Mother Nature says this is when the babies to be born, they schedule them, and ACOG, which is a organization for obstetricians and gynecologists as well as leading authorities like March of Dimes have said, don't do these deliveries. They're not safe for the babies, they’re not safe for the moms. The NICU are populated too often with babies that come from these early elective deliveries.

So we started reporting on these back in 2010 and we found a rate of 17% which was far too high. We found some hospitals had a rate like at 40% or 50% and another hospital would have a 2% rate. So once I think hospitals saw for themselves the variation and recognized too many of these were happening, they took it on, and so since 2010 that rate has gone way down, it's plummeted. Today it's about 2.8%. It's something that we knew we could address. We all knew it was a problem and we made it transparent and now they're down. So we can do same thing with maternal mortality, but we're going to all have to work together and we're going to have to make this public.

Mark Masselli: You know, Leah, I want to pick up on your phrase there of transparency. When I'm in New York City and I'm going to a restaurant, I look at the sign outside. It's either an A, B or C. I don't go into B or C. Why aren't we after our lawmakers to say, every hospital should post big letter outside that this is an A, B, or C, what can we do to get this grading system adopted if it's good for us in terms of eating, my God, it's got to be much more important if we're going into a hospital to know that we've got a C rating and we have no idea?

Leah Binder: We actually designed our letter grade system, our Hospital Safety Grade, exactly around the New York City restaurant ratings. It was also done in LA, and in LA, they actually had a couple of studies that showed that once they implemented the letter grades for restaurants, they saw a reduction in emergency visits for food borne illness. We're not trying to legislate anything, but certainly what's important to us with our letter grade is for the public to use it. By the way, purchasers and health plans, anyone who's paying for large amounts of healthcare, employees of a state or the employees of the city are run by a government, they should be demanding As. People who go to a hospital, if they say, wait, you don't have an A, why don't you have an A? If they even just ask the question, it can make a big difference.

Hopefully they do more than ask the question. They also say, well doctor, I know you want to schedule me in that hospital, but I'm not comfortable because they got a D and I'm just not comfortable there. So is there somewhere else? This is something where our lives are threatened. Hospitals need to hear from the public, and the best way to remind them is the old fashioned marketplace, the same marketplace that tells restaurants if you get less than an A, I'm not going there. The way that states, cities, municipalities, all kinds of government entities, purchase healthcare. They should be demanding this in their contracting, that should be a critical element. No hospital that gets a D should be on some Center of Excellence list. So there's ways that I think we can all work on this and we are beginning to see momentum and people doing exactly that, really using this grade to send a message about the importance of safety.

Margaret Flinter: We've been speaking today with Leah Binder, President and CEO of the Leapfrog Group, an independent nonprofit organization that's dedicated to improving safety and quality in American Hospital Care. You can learn more about their work and access their latest report by going to www.leapfroggroup.org or follow them on Twitter

@LeapfrogGroup. Leah, we want to thank you for your ongoing commitment to exposing causes of harm in healthcare and for joining us on Conversations on Health Care today and bringing this really important information to the American public. Thank you so much.

Leah Binder: It was a pleasure, and thank you so much for raising awareness about so many issues including this one.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: A Twitter spat between President Donald Trump, his son Eric and New York City Mayor Bill de Blasio touched on the public health issue of crime. The Trump claimed crime has risen in the city under de Blasio's leadership, but that's wrong according to crime data kept by the New York Police Department. Major felony offenses have dropped every year de Blasio has served as the city's mayor according to NYPD data. Other felonies are down, misdemeanors are down, arrests are down. According to FBI crime data, New York City had a lower violent crime rate than all but two other cities with a population over 1 million in 2017. Nonetheless, in a Twitter spat with de Blasio on May 14 Eric Trump claimed that under de Blasio's leadership, "Crime is up in New York City." Two days later, de Blasio, a Democrat, announced his bid for the presidency. That prompted President Trump to sarcastically tweet that, "If you like high taxes and crime, he's your man." As a mayoral candidate in 2013 de Blasio vowed to end the controversial stop and frisk policy, a get tough on crime tactic of stopping people for suspicious activity that was begun under Former Mayor Rudy Giuliani and expanded under Former Mayor Michael Bloomberg. As it faced court challenges, the policy was well on its way out by the time de Blasio took office in early 2014, but it was greatly reduced during his tenure. Although many critics warned it would spur a return to higher crime rates, that didn't happen. Patrick Sharkey, a sociology professor at New York University, told us, "Crime is definitely not up under de Blasio." Last year was the lowest murder rate on record for the city, he said. In 2017 New York City's violent crime rate was the lowest since at least

1985. And that's my fact check for this week, I'm Lori Robertson, Managing Editor of FactCheck.org.

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Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at www.chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. According to the World Health Organization, some 35 million people suffer from some form of dementia and 65 million people are expected to develop dementia by the year 2030 and still no cure on the horizon. But studies show those dementia patients who remain more active who stay outside the clinical setting are more likely to have a much better quality of life. And that's the basis for a first of its kind dementia village in the Netherlands Hogewey an enclosed village built to look and feel exactly like a normal village but designed to house patients with advanced dementia.

Yvonne van Amerongen: One of the things that are very important to people with dementia is that they don't understand what's happening. We try to help people understand what's happening and let them feel that it's okay.

Margaret Flinter: Co-Founder Yvonne van Amerongen says, these patients have lost their ability to process new surroundings and the enclosed village provides a safe and pleasant environment for them to live where they can walk, socialize, remain engaged. The village was built with 23 connected housing units where a patients are group based on their earlier personal lifestyles, whether it was interested in the arts or music, academics, gardening, and all living areas are manned 24x7 with trained clinicians who help to maintain a sense of normalcy as well as safety.

Yvonne van Amerongen: Those people you live with should be people that –

Margaret Flinter: And the director says, relatively no need for excess medications or restraints that are so commonly used in dementia wards in so many nursing homes around the globe. In a way, some have compared it to the movie The Truman

Show, but the village co-founder says it's necessary to maintain a predictable routine. A planned and closed residential community designed to maximize quality of life for dementia patients, creating a life with dignity for patients who might ordinarily be institutionalized, sedated, or restrained, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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